DEPARTMENT OF MEDICAID SERVICES
BEHAVIORAL HEALTH TECHNICAL ADVISORY COMMITTEE

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Capitol Annex
Room 125
Frankfort, Kentucky

March 11, 2020
commencing at 2 p.m.

Kathryn Marshall
Court Reporter

PRESENT:

Sheila A. Schuster, Ph.D, Chair
Mike Barry
Steve Shannon
Cathy Stephens
Diane Schirmer
Michelle Douglas
Cat Jones
Nick Love
David Crowley
Michael Cox
Lori Gordon
Susan Abbott
Rachel Smith
Monica Hawkins
Margaret Pennington
Ken Burke
Aimee Man
Liz Stearman
Karri Coburn
Natalie Harris
Kathy Dobbins
Johnny Callebs
Pat Fogarty
Micah Cain
Christy Price
Liz McKune
Tracie Horton
Phyllis Millspaugh
David Hanna
Lisa Lee, Commissioner
Mark LaPalme
Kevin Horn
Allen Brenzel
Sarah Anne Barton
Brigid Adams Morgan
Colleen White
Dustin Johnson
Lorenda (Lori) Kelley
David Cassbe
Kathy Adams
Sarah Kiddow
Julie Paxton
Adrienne Bush
Tiffany Cole Hall
Bart Baldwin
Gayle DeCesare

DR. SCHUSTER: I guess we'll get started since all my handouts are almost all gone. I'm Sheila Schuster, the forever Chair, I guess. There's Gayle back there. Did you get some material?

PARTICIPANT: I just came in.

DR. SCHUSTER: Okay. So we have five of our six TAC members are here, and as we go around and make introductions, they can introduce themselves. Let's start over here with the good Dr. Brenzel.

DR. BRENZEL: Allen Brenzel, medical director of Department of Behavioral Health and Developmental and Intellectual Disabilities.

COMMISSIONER LEE: Lisa Lee, Commissioner, Department of Medicaid Services.

DR. SCHUSTER: Welcome back, Lisa Lee, to the Department, and welcome to the BH TAC. We're very glad to have you.

(INTRODUCTIONS)

DR. SCHUSTER: Great. So we're delighted to welcome some of the private childcare providers as well from the Children's Alliance, and we have a full agenda so we'll get going.

On your salmon-colored sheets, so we've done our welcome and introductions. I probably have this out of order. I didn't want to put my two colored sheets together. That's why they're separated by a white sheet.

So on the blue are the meeting minutes from our last TAC meeting, and I think I sent these out electronically, didn't I? So if a member of the TAC would make a motion for the approval.

MR. BARY: So moved.

DR. SCHUSTER: Mike.

MR. SHANNON: Second.

DR. SCHUSTER: Steve seconds. The TAC members all in favor signify by saying aye.

(MINUTES APPROVED)

DR. SCHUSTER: And the minutes are approved.

This, basically, for those of you who are new here, this represents basically the report that I give when I go to the MAC meeting. So a TAC is a technical advisory council established in statute, and there are about 22 of them. Many of them are provider groups like nursing and podiatry and optometry, and then about, what, Steve,

seven years ago or so we realized that we didn't have a voice for behavioral health, and so we did a piece of legislation to create the Behavioral Health TAC, and at the same time the children's health groups wanted to come together, so they created a children's health TAC. And in that same piece of legislation, the therapy groups, the OTPT and speech were also established. We're going to talk later on about a piece of legislation to put a couple of new TACs in there.

So the TACs, you know, kind of around here and then they report up to what's called the MAC which is the Medicaid Advisory Council, also in statute, and that has about 18 members. Again, some of them are representative of the TACs, but they also are specific representations of different populations of people that are covered by Medicaid. So there's somebody that's on there for the elderly and the children, and those with disabilities and so forth.

So the idea is that we come together, we make recommendations that we vote on, and the TAC members are the ones that are appointed by the governor, those six members. We make recommendations, and then we take those to the MAC

meeting. We make a report about what we talked about in our meeting. We give those recommendations, and then the MAC, if they have a quorum, which lately they have had a quorum, which is good. They meet every month. And then they carry those forward to the Department for Medicaid Services.

So it's a nice pipeline, if you want to think about it. And in the past, actually before this last administration, there was a great two-way pipeline. We had a lot of attendance here at our TAC meetings from the Department for Medicaid Services as well the Department for Behavioral Health Developmental and Intellectual Disabilities.

So we did some good problem-solving. We asked for all of the MCOs -- there are now five operating in Kentucky -- to send at least one representative, and I think we -- I don't know that we've ever had a TAC meeting where we didn't have all five represented.

So those of you who know me know that I don't think there's ever a tent that's big enough to bring everybody under it, so I conduct these as open meetings where I want our TAC members to hear

from people that are out there really on the front lines. So we're very open to input from providers, but also from consumers, themselves, from family members, and from advocates. So we have representations at these meetings from those various groups, and we try to solve some problems. We try not to get into the nitty gritty about specific claims and that kind of thing. We're really trying to look at, you know, kind of overarching issues.

We had a lot of issues where we were concerned about the 1115 Medicaid waiver that the previous administration had submitted to CMS. We were especially concerned about what would happen to our folks who had behavioral health, acquired brain injury, developmental intellectual disabilities and how they would be impacted by that. So we're delighted that that has been put aside now, for those of you who probably have followed this, it was thrown out by the federal courts on three different occasions, actually. But then Governor Andy Beshear, almost as soon as he took office actually formally withdrew the waiver so we're not operating under that.

So one of things we're going to talk

about today is targeted case management. Margaret and I were laughing for a minute. I said, how many years have we talking about targeted case management? Because it is -- you know, we see it is as a lifeline for our folks. It's a thing that probably keeps them safe and hopefully on their medications and some kind of treatment routine; hopefully, gets them housing when possible, and keeps them out of the hospital or out of jail or, you know, out of homelessness.

MR. SHANNON: Some folks have told me it's become more significant with the Coronavirus that that's the vehicle that gets people in to see the doctor to see that that connection is made.

DR. SCHUSTER: Right, because it's very often the targeted case manager who makes sure that they're holding the person's hand. They're making sure that they get to the services.

MR. SHANNON: That just came up today.

DR. SCHUSTER: Okay. Good point. So at the last MAC meeting, was the first one that Commissioner Lee had been at. I think you had been on the job for two days. So we didn't ask

for a lot of report. Stephanie Bates made a report and so forth. That actually was probably one of the quickest meetings that we've had because I think with the change in administration everybody was pretty much a kind of getting to know kind of a MAC meeting, but we would go forward with more discussion at the next meetings.

For those of you who were not here last time, the issue of targeted case management came up, and we had quite a, I think, robust discussion. This has been an issue that providers have been concerned about, certainly the comprehensive care centers, but also other groups that do targeted case management. And, fortunately, Dr. Brenzel was here. Stephanie Bates from DMS was here, and all of the MCOs, and the various MCOs kind of talked about some of them approved targeted case management without any prior authorization. Two of them used prior authorization, and that's where, I think, some of the problem has come in. They are approving it for maybe three months and then nothing after that, and I think most of us see our folks as having chronic conditions that really are never cured in that sense. We want to maintain people

and keep them in a safe, again, as safe and recovery-oriented situation as we can.

So Stephanie had volunteered to talk to the MCOs and get their input, look at their medical necessity criteria. I sent her, I think, two batches of information that I had gathered from the CMHCs. I asked them to look at what their targeted case management was from four years ago and what it was this past year so that we could see that difference, and I think I heard back from nearly all of the 14 CMHCs. I put that together without their names on it and compiled that and sent it over to Stephanie. And she, I believe, met with you, Dr. Brenzel. There was some discussion between DMS and DBH and so forth.

So I guess I'm going to turn to Commissioner Lee and Dr. Brenzel to tell us maybe where we are with this issue.

COMMISSIONER LEE: Well, thank you for letting me come here and talk a little bit about Medicaid, and I think before I jump into targeted case management, I just want to take a little bit of liberty and talk about Medicaid, in general, and some of the things that have been going on, and some of the direction that this

administration wants to take. Dr. Schuster, I'm very glad to hear you talk about priorities and how we want to move forward with positive policy decisions. So one thing that we think has been definitely missing from the MAC and the TAC is data. So we want to get some information out to the TACs, particularly Behavioral Health TAC, to make sure that we're driving positive policy decisions. We don't think that you can make decisions about anything unless you see what's going on, so you really need to see the data.

The other thing is you know that this administration is very open about our priorities and removing barriers to care. We want to increase access to care. We also want to increase access to enrollment and eligibility processes. So we're going to concentrate on that.

If you haven't heard some of my talking points, there was a report from Georgetown University a few months back, and it showed that the number of uninsured children in the state is increasing rather than either staying steady or decreasing, so we think that that is an issue. So that's going to be a priority.

For those of you who don't know me, I

worked in Medicaid before. I have 16 years in the Department. So I have a little bit of background about what goes on and some of the priorities, and my philosophy is the Medicaid program was created for the Medicaid member. We are here to provide healthcare services to a very vulnerable population that does not have health insurance, cannot access health insurance. As you know, Medicaid is typically -- Medicaid is the go to program to solve issues that cannot be solved, healthcare issues that cannot be solved in another arena. For example, Medicaid is the only program with a child-specific benefit, the EPSDT benefit. Private insurance companies do not have that benefit. We are the only program that provides personal support services to help individuals remain in their home and community rather than in a long-term care facility, and we are the number one payer for long-term care services. So we have a big job.

I appreciate every one of you in this room and what you do to serve our members and look forward to working with you as we make positive policy changes to the program to help all of our members and improve the lives of those that we

serve.

So with that, I think I can jump into the targeted case management now and get back to the agenda. I just wanted to take that little bit of a liberty there.

DR. SCHUSTER: Thank you. I appreciate that.

COMMISSIONER LEE: So on targeted case management, Stephanie, shortly after this, I guess, your last meeting, she has been assigned to a special project so she'll be out of pocket for a while. I do know that she met with Dr. Brenzel, and there were a couple of other individuals in the room. I've been given a summary of that meeting.

I don't know, Dr. Schuster, that they pulled data related to targeted case management to see if they have the trends, but I will go back and request that.

We've been a little bit busy with Covid-19 and just a little bit of that, too. We did two provide letters. They went out today. One was for the entire provider population in Medicaid outlining billing procedures and some codes and things that we are doing to promote or

to increase access to treatment and identification of anyone with Covid-19.

We also did a letter specifically to home and community based waiver providers because they are a little bit different.

So I will go back and get on that data, but there was some discussion about requiring, and if the MCOs are in the room, I don't know if they've heard this, if it's been discussed with them, yet, but there was some discussion about requiring the MCOs to use the criteria in the targeted case management regulation as far as authorizing services.

DR. SCHUSTER: You all have that. That's the highlighted -- that's not the whole reg, but what I did was put the eligibility part there.

COMMISSIONER LEE: So there was that discussion, and I'm not sure what has been taking place since them, but Dr. Brenzel was in the meeting if you want to give some --

DR. BRENZEL: Yeah. I mean, I think shortly after this meeting, we had a meeting directed by Commissioner Lee with several of her staff that are involved in managed care. We had

the information that you mentioned. What was clear is that there seemed to be some inconsistencies in the interpretation of medical necessity for eligibility, and so I think at that point the discussion was had about what should be the eligibility requirement and if there is a regulation, and if a Medicaid enrollee through a state plan is entitled to a service and there's a description then should that not serve as the eligibility. So I think that was something that the group easily began to develop some consensus around.

There was also a discussion of what data did we want to have because the assertion where I sit as often in a position of hearing from providers directly and then advocating for services is that do we have data to show that there is less targeted case management being initially authorized than there was in the past. If it's not initial authorization, is it the duration of authorization or is it the frequency of concurrent reviews that are the issues? So there was a plan to ask for specific data from each managed care around that and then compile that.

It was a little challenging to put the data from the CMHCs together. It wasn't all apples to apples and --

DR. SCHUSTER: That's what happens when you send out an e-mail to 14 providers and you say, you know, give me the numbers. We can fine tune that for sure.

PARTICIPANT: I would also add that that data should include people that have been dropped from targeted case management.

DR. BRENZEL: So who once received it who were then denied.

PARTICIPANT: We know of 1,400 people in Louisville alone who have been dropped.

DR. BRENZEL: Who received the service for a period and then were dropped. Okay. So that would be an important data element, I think.

But there's general receptivity, and I think you can tell from Commissioner Lee's philosophy that this is a service that most of us in this room know is cost-effective. It leads to often folks avoiding higher cost services, and it can be a life-sustaining intervention for a number in both the world of serious and persistent mental

illness, but also in substance abuse. We know it's a particularly important benefit in the time of the opioid crisis and now with methamphetamine. So I feel confident that we've got the attention of the new administration, and what we need now is to get that data and then look at our ability, and then I think Medicaid will exercise its authority to inform the managed care organizations of what criteria -- there's always some complications in that in terms of contracts and actuarial calculations and things like that, but I know that the commissioner intends to utilize the authority that we have to -- I don't know if you need any additional information from them or testimonial from members, but have we seen any changes in -- since we've met last? We're still getting situations where initial denials are the problem or it's ongoing renewals that are the problem, or is it kids, adults, all of the above?

MR. SHANNON: I haven't heard any reports to me that things have changed.

DR. SCHUSTER: Kathy?

PARTICIPANT: Our community behavioral health providers met this morning, and very clearly I heard that things have changed that

in the negative, unfortunately, that where we had heard historically that some MCOs limit it to 200 hours of services. That one now has limited it to 114 hours.

DR. BRENZEL: That's total?

PARTICIPANT: Uh-huh. And so we've asked MCOs to let us know how they interpret what is that 200, what is the 114, what period of time does that cover? You know, is it that somebody can only have that many units a year, two years?

So those were some of the things that we heard this morning.

DR. BRENZEL: That would be primarily children?

PARTICIPANT: Yes. And another big issue was that children have to have a therapist before they can get targeted case management, and if they're getting four units of TCM a month, then the expectation from the managed care company is that they would have four therapy visits that month, and very clearly we're trying to prevent folks from having to access therapists all the time especially if it's not needed. So that was a big concern.

DR. BRENZEL: It's helpful.

PARTICIPANT: We've come up with -- there were five different issues listed and --

DR. SCHUSTER: Natalie --

MS. HARRIS: I'm Natalie Harris --

DR. SCHUSTER: Louisville.

MS. HARRIS: -- for the homeless.

DR. SCHUSTER: In Louisville.

MS. HARRIS: And I'm particularly interested in the adults. We house 1,200 seriously mentally ill chronically homeless adults in the city through all of our members, including Wellspring and Center Stone who have seen 13 to 1,400 people dropped. That includes the children, as well.

DR. BRENZEL: Over what period of time would that be, that number?

MS. HARRIS: That's over the last year.

DR. BRENZEL: One year, last year.

MS. HARRIS: And the thing that's frustrating is that we worked really hard with the state and with the MCOs. We went to Louisiana. We came back. We went and did a Medicaid academy in Washington, with the state employees, and came up with what was needed to make sure that people

could get in supportive housing and stay in supportive housing that were mentally ill because we do have, and I have copies for you all. We have a history of the cost savings of targeted case management and supportive housing, and a list of the items that we brought to the state that needed to be included in services, and we were told by the state that all of those things were part of targeted case management and would be covered. We're spending $8 million a year on supportive housing. What we need in exchange is the services that allow those people to stay in those housing units, and being able to have that saves the state $10,800.00 a year in other medical costs when those people are hospitalized or overdose or do something else.

PARTICIPANT: That's per person, right, Natalie?

MS. HARRIS: Yes. 10,800,000 per year just for the people in Jefferson County. I'm not talking about the rest of the state because I don't have that data. And so what we're finding now is that, one, MCOs are redefining what targeted case management is. It no longer includes that whole list that we agreed to before.

They're limiting the term of what targeted case management is. We have people from Wellspring that have not even gotten into housing, yet. They're still sleeping on the street, and MCOs have determined that they are no longer qualified for case management because they don't have that need anymore, and they haven't even gotten into housing, yet.

We're getting the cart before the horse. They're required to get therapy before they can get case management, and most of these people are not prepared for therapy at that point when they're living on the street. They need the case management first to be able to get to the other things. And in some cases the MCOs are requiring that they have two therapy sessions per month before they can qualify for case management which is actually is not even possible sometimes to get two appointments, and then it's very -- it's hard for people to actually make those appointments. And it's actually seen as a requirement.

So at this point what we're doing in Louisville is I'm actually telling lots of clients don't choose these MCOs that are requiring medical necessity for targeted case management, and I'm

saying that very openly, and I want the MCOs that are here to know that, that that's what I'm saying, and I have told the CEOs of those MCOs that that's what we're doing.

We've gone to the Kentucky Center For Investigative Reporting to cover stories of people who have been dropped who have overdosed, who have died, who have had other issues happen to them, and we're looking at other things, but we would rather it just be addressed at the state and that people get the services they need and we save the costs that we're spending on all of this happening to people.

COMMISSIONER LEE: Definitely good information and we get that data and get the information so that we can look and make sure that we're moving forward in the right direction for our members.

DR. SCHUSTER: Kathy or Margaret?

PARTICIPANT: I just have a basic question about the need for the prior authorization for that particular service once it's been determined that that individual meets the statutory definition for being severely mentally ill, and so once that's occurred, that

there is a diagnosis, the term of duration is met, the term of disability is met, then it seems to me that those people who really know about people's severe illness would not feel a need every three months or whatever to rethink whether they're still eligible. If they're doing well with services, it's because they're doing well with services, and their functionality, their brain chemistry has not changed during that period to make them do better. It's the services that have accomplished that. And it just seems to me that we're at a particular point in time where you all are negotiating contracts, writing the language for contracts, that this would be a perfect time to be able to appropriately decide those kinds of rules for this population don't make any sense.

DR. SCHUSTER: Yes, ma'am.

PARTICIPANT: So I direct a program that serves ages 12 to 21, but I'm also a therapist who provides services to that population, and one thing that we see because I have to talk to MCOs all the time to get things approved is that we serve a population of youth who are referred to us because their, generally,

their parent or legal guardian is not involved in their life at all, and these youths need targeted case management. So to have to have one parent or legal guardian contact a month to be able to reimburse for the services we're providing, sometimes we can't even get a hold of a parent or legal guardian. I know there's a bill coming about homeless youths, but these are youths who are not technically homeless, but their parents could probably care less. If a youth can -- is age of consent for mental health services or SUD services like at 14 or 16, then why can they not consent to this? What was told to me was, well, this is not a clinical service. But it requires a clinical diagnosis, and when I'm talking to MCOs to get TCM approved, they're asking for more and more clinical criteria and documentation. I'm talking about treatment plan goals, and it is a clinical service then if that's what you're requiring.

So we have kids who can't get services or we're providing them for free. We don't have the resources to do just like a lot of these other agencies, but we're also ethically obligated to not abandon a client if an MCO decides, well,

you're done at three units, we're not even going to give you one at close. That's not appropriate.

So we're eating that cost and we just can't afford to do it anymore, and these kids can't afford to not have services.

DR. SCHUSTER: I'm sorry. Who are you with?

PARTICIPANT: The Methodist Home of Kentucky.

DR. SCHUSTER: Great. Thank you.

MS. DOBBINS: Kathy Dobbins, Wellspring. I think Natalie did a great job covering the issues in Jefferson County, but I would add that some of these folks who are on the streets who are chronically homeless and severely mentally ill are acutely symptomatic. They've been out there for a long time and to not look at the functioning of the individual to make decisions, but making decisions based on some sort of a timeframe, arbitrary, and harmful to those individuals who need the service.

DR. BRENZEL: I think potentially a parity violation because limitation of services should not be based on diagnosis or illness. So we can't have limitations in one service that are

not --

MR. SHANNON: There's no limitations in waivers. I give you a population, you get 15 minutes, you get 15 minutes.

MS. DOBBINS: And some of these clients are so symptomatic that outpatient therapy is not the treatment of choice in that point in time. They need concrete services that help them get housing and support in order to be in your community.

DR. BRENZEL: I think you know our new secretary worked in Louisville and is very familiar with the efforts in Louisville and the population that you all serve and has very much directed us to look at addressing these issues so we're grateful to have --

MR. SHANNON: This isn't a Louisville issue.

DR. BRENZEL: Right. But I just want you to know that our secretary knows firsthand about the urban nature of the issue. I'm sure this applies equally across the state.

MR. SHANNON: Grayson County at one point had nine case managers serving the county. Now they have three. The population hasn't

changed.

DR. SCHUSTER: Adrienne, what do you hear from your other homeless folks around the state? Adrienne is the director of Homeless and Housing Coalition of Kentucky.

MS. BUSH: So what I hear I know reconciles with what Steve just said. It's not just urban problems. It's across the state. When I initially reach out to folks about issues they receive with Medicaid, I thought I would get a good response from our homeless service partners in Lexington and Louisville, and then when I opened it in what we call balance of state, my e-mail blew up with issues. So while we don't have quite the data collection method, but Natalie and the coalition do because they're a single county, and we also know that an anecdote is not the plural of data, we are in the process of trying to get that information because I agree, like it's hard to make good decisions if you don't actually have the data, but our initial -- our initial conversations are indicating that, yes, this is an issue with multiple MCOs and in multiple communities, and it doesn't have an urban or rural --

MR. SHANNON: I think under data the number of PA requests by a provider because the experience I've had is people figured out these folks aren't going to get approved so we're not going to go through the administrative --

DR. BRENZEL: Stop requesting --

MR. SHANNON: -- to submit a denial. We're just not going to do that. Whether that's good policy, good practice, we're not doing that. We're referred about a third of as many people as we were. So that's another data point --

DR. BRENZEL: Number -- number of requests.

PARTICIPANT: And I'm hearing that from our members as well. Some of them are just worn out with asking so they just quit asking.

DR. BRENZEL: That's a good point in terms of interpreting the data.

PARTICIPANT: Another thing that may be helpful in understanding the issue, I don't know, is that private providers haven't been in the behavioral health network only since 2014. So it might be helpful if you can compare BHSO, behavioral health msg data with the community

mental health center data since they've been around a much longer time to see the disparities between those two subsets.

DR. BRENZEL: That's a good idea. And adults and children and SUD and --

MR. SHANNON: SUD is new really.

DR. BRENZEL: Since '14 as well. I don't know if any of the MCOs want to comment on it. Do any MCOs want to comment on it?

COMMISSIONER LEE: It's up to the Chair.

DR. SCHUSTER: Absolutely. We're open to hearing from any of the MCOs that want to weigh in.

PARTICIPANT: I will say the same thing I said last time. We submitted data, so it should be there somewhere. But I would be very curious to talk about outcomes for TCM. We talked about could we get a collective together to talk about what are the outcomes and what are we seeing. So I heard as you all were talking: Keeps out of jail; keeps out of the hospital; increases medication compliance; decreases homelessness; increases PCP compliance; reduction in therapy costs or therapy visits. But like I

would love for us to have like a global conversation about what are the outcomes that we're hoping for with TCM and where are we seeing those. Do we see a difference? Is there a different model for kids or adults or for SMI? So I know that we talked about, you know, let's look at the data, but I really think a conversation around what do we do long-term? You know, is this something that is active and it steps down to TCM, and then is there another level of case management? I know some states have done that. And then what are the global health outcomes. So just as we're talking about dreams, I'd like to see that, too.

DR. SCHUSTER: So did Stephanie ask you all to submit --

PARTICIPANT: She sent me an e-mail while she was sitting here so I had it by the time I got back. So that data is all somewhere.

COMMISSIONER LEE: It's compiled -- we'll go back and look.

PARTICIPANT: While we're dreaming about data, I think a lot of the points that Lori mentioned deal with social determinates of health. And those are a lot of the unmeasurable like

unchecked boxes that come along with the territory that really do impact the pre-imposed longitudinal outcome. So if we're going to dream, dream big, but trying to capture some of those social determinates --

DR. BRENZEL: But my thought would be is that the MCOs were interested in addressing psychosocial determinates of health. This is one significant tool that you would think would allow them to do that, and so it's of concern to me that you would be limiting that service because we know healthcare is not going to address all of the psychosocial determinates, but to the degree that the benefit plan allow that and that it's a covered benefit and it's a service that should improve, those psychosocial determinates I would see to be -- and I do agree outcomes are important; however, we don't measure in limits other services based on outcome.

PARTICIPANT: I think we need to say because I've heard several people say that we know that this works. Well, do we? Do we have data in Kentucky that --

PARTICIPANT: Yes.

PARTICIPANT: Right. But for what

population, for adults, for kids, for substance? Because we haven't been able to prove that internally.

DR. BRENZEL: So you have data that refutes that it creates any positive outcome?

PARTICIPANT: We see that it creates a positive outcome in about three months, but then that starts to decline at nine months. And for people who have been in TCM longer than 24 months, the correlation is actually opposite. So we'd just like to bring it all in --

DR. BRENZEL: It's about improving the quality of the service.

PARTICIPANT: At Anthem, we don't require prior auth for requiring case management, but I don't have any data to say this is what we see pre-imposed.

PARTICIPANT: I'd like to look at it globally.

PARTICIPANT: I was thinking about when you're writing a TCM plan for a kid because the authorization is coming from the child so at three months maybe the goals are like we're going to try to keep him in school, we're going to try to make sure they have clothes. But then when you

get beyond that, you have to be more and more creative because these kids live in a contextual system with parents who aren't actually eligible for the services. So you're trying to go through this one kid who you ultimately do want to keep out of the hospital, but you're trying to work with the whole family to create this situation where they thrive, but it's all being funneled through this one kid.

So I don't know how you write a plan that fixes the entire family system while making the case to MCOs that this would be better for everybody if we could keep this kid afloat by family. So I can see how you have these temporary like, oh, they could make it to the end of the school year, but we haven't been able to touch what's going on in the kid's house.

PARTICIPANT: Maybe we need to call it something else. Are we calling it something that's it's not? And that's the clinical curious brain that goes in my head. Like so, you know, I'm sorry. I'm talking too much. I get really curious about that stuff though.

DR. SCHUSTER: Anybody else have anything that they would like to add? Subtract?

A question?

So what would you suggest would be the next step? Do you need some other kind of data from providers?

COMMISSIONER LEE: I think I need to go back and review what's been submitted by the MCOs and kind of see if it's in a format that we can even put into a report to send out prior to the next meeting so we at least come ready to talk about we see, where some of the gaps are, and how we fill those while we start also talking about what are the outcomes we're trying to achieve and how can we measure those. And I think the first thing is to get that data together, see what's missing, see if we need to do another report, but at least get that to you guys definitely before the next meeting so we can all be thinking about it and talking about it when we come, be definitely more prepared to what's happening, where the gaps are.

DR. SCHUSTER: Is there anything we can do in the interim? I'm aware that we've got people out on the street. I guess I have a real concern about that, quite frankly.

COMMISSIONER LEE: I think in the

interim, we are all definitely concerned about individuals and making sure that they receive their services. So once we look at that and we notice that there's a big disparity between one MCO or another, the Department will contact that MCO and speak with them directly about what sort of measures that we can put in place.

DR. SCHUSTER: Is there any kind of safety net -- I'm concerned about 1,400 folks that have -- which is really scary to me, I mean, regardless of whether we know exactly what the value of targeted case management is. I think we would all agree that 1,400 people out there that no longer have that service is a real problem, and I guess I wonder, Commissioner, if there's anything in the interim -- can we lean on the MCOs to say you can't drop anybody until we meet again? What kind of power do you have?

COMMISSIONER LEE: I was told at one time I had a big hammer, but I've yet to see that. I think without really looking at what I have on my desk, I'm hesitant to say go forth and just give everybody that requests TCM TCM, but I definitely want to help with those that are falling through the cracks right now, and we want

to focus on the MCOs that appear to have different criteria than the others and make sure that they are following the regulation.

DR. SCHUSTER: Well, I think we're talking about only two MCOs that are doing prior authorizations.

PARTICIPANT: Three.

DR. SCHUSTER: Three? Passport, Wellcare and --

PARTICIPANT: Humana only requires it on if there's two modifiers. So we're sort of a partial.

DR. SCHUSTER: You're a halfway?

PARTICIPANT: Yeah, we split the baby here. But, yeah, if you have TG or HF modifier then it requires --

PARTICIPANT: Tell us what that means in English.

PARTICIPANT: All right. If you're billing it for an SUD service because we are seeing some pretty concerning trends for some of the SUD providers that are new to the state and if we're utilizing maybe that service as a stop gap measure for other services that are no longer as available to them. So we've got those on prior

authorization. And then the other one is the complex modifier that requires that you have both a behavioral health and a physical health condition and some of that has to do with not only tracking those members and making sure they have medication and case management, but also those are -- obviously, those are the members that we want to be very aware of the services that they're getting. So we've sort of split it.

COMMISSIONER LEE: I guess a question I have, too, is you've been talking about targeted case management for a long time. Did the MCOs not have prior authorization, then all of a sudden they created prior authorization, or was that -- have you always had prior auths for targeted case management?

PARTICIPANT: We've had it for Wellcare. It's been at least since '15.

DR. BRENZEL: But I think some of the changes have been limiting the duration so we've had a significant number of people reach what was an arbitrary limit on duration of services so that you started to see a significant -- so it may not be as much as the initial auth as duration. That's what our data will tell us,

right, if there's decrease in duration of service because if you had 1,200 people who had it for 24 months and then somebody creates a policy that there's an arbitrary limit, then you're going to drop all those people at once. We're looking at data to see if there's anything that indicates --

MR. SHANNON: Three months and then you go back a month at a time and month at a time.

COMMISSIONER LEE: So that overarching issue really not so much the prior auth upfront but having to keep getting it all the time, that may --

MR. SHANNON: And that change of policy.

DR. BRENZEL: The administrative burden of the initial auth is a problem.

PARTICIPANT: And I will say, I mean, it's not -- it is harming people, but like the example you gave that we've moved in Louisville at least $1,054,000.00 of money that should go to housing is now being spent on case management because those people were dropped, and so these agencies have to be able to do that. There's some agencies that haven't been able to so the client has just been dropped and they lose

their housing and back on the street. And then we returned $350,000.00 to HUD because we didn't have enough case management to fill the units.

MR. SHANNON: That million dollars probably wasn't, right, wasn't matched with anything?

PARTICIPANT: No. It was money that we would have used for housing, but instead we used it for case management. We were able to move -- the other three hundred and fifty we couldn't move, and it was housing money, and there was no case manager, so we just returned the money to HUD.

DR. SCHUSTER: So let me ask Passport. Has there been a change in the way that you authorized or preauthorized targeted case management over the last two years or so, Liz? David?

MR. HANNA: So the only change that we've made is the change that we made earlier this year to require targeted case management by CMHCS and I would just echo Lori's point about people looking at what the data actually shows in terms of the impact of targeted case management.

COMMISSIONER LEE: And I think I've

heard that we really don't have anything that we can look at right now. There are no measures. So the overarching concern, of course, is are our individuals receiving the right services at the right time and the right location. And if I'm hearing that 1,400 individuals have dropped off of case management, do we know these individuals are still Medicaid eligible and they're not receiving service or are they just dropped off of the --

PARTICIPANT: You're still trying to hold as many them up in other ways as well.

PARTICIPANT: Yeah. You know, when a client needs a service and they don't get authorization for case management we look at peer support, can peers help. We are also providing free services, which we cannot afford to do, and sometimes we're dropping them from the rolls because we just can't afford it. You know, in terms of being able to look at outcomes, you know, it can be difficult when a client is doing better because they're receiving case management. They're not going to the hospital. Their costs are down in terms of emergency services. You know, it can look like they don't need this anymore. But if the person is nearsighted and

they need glasses, then they can see, do we take their glasses?

DR. SCHUSTER: Because they're seeing, yeah.

PARTICIPANT: I can't speak to all populations, but we have plenty of Kentucky studies that show if you're talking about the chronically homeless, severely mentally ill that there is a huge cost savings to providing supportive housing versus having that person hospitalized over and over and over again, and we can share all those with you, as well.

COMMISSIONER LEE: So we're all here in the room for the same reason. We're here because we care about our members, and I'm going to ask my MCOs here today to work with me to relax these preauthorization requirements to make sure that individuals, particularly those individuals with severe and persistent mental illness are receiving the targeted case management that they need. I'm going to ask you, providers, to contact me or my staff, Angie Parker, who is over quality and outcomes, if you continue to see major issues with targeted case management until we can get this data and we can look at it and we can move

forward in a positive manner to make sure that we are providing the targeted case management that we need to make and, again, bringing the data in here to look to see what's happening to these individuals that are getting targeted case management. Are they maintaining a stable life in the community? And if they are, then it would suggest that targeted case management is working for them. If they continue to go in and out of treatment for whatever reason, we need to look at that, too, because, again, our overarching goal is to make sure that our members get the services that they need, and we'll continue to work with everybody in this room to make sure that that happens. And I think the only way we're going to solve this is to continue to look at data, look at the targeted case management that's being provided, and looking at some of the outcomes as best we can developed in this room as a group.

DR. SCHUSTER: And I can offer, obviously, my services as the chair for you to send that information to me if you want, and I can send it to Commissioner just so we know that we've got it all gathered, however you all want to do that. And we can go back and look at the CMHCs

and some of the other providers more specific questions if you let us know what those data points are that you need.

COMMISSIONER LEE: I'll look at the original information that the MCOs have sent and, Lori, do you know did she ask for prior authorization --

PARTICIPANT: I don't think we got which one said the data. That would have been interesting --

COMMISSIONER LEE: The number of requests versus the number of denials?

PARTICIPANT: We did that. We didn't do SUD or SMI. We did adult and child, but we didn't, in what we sent to you, we didn't break it out CMHC and non CMHC, I don't think. So we didn't break it out, which was said today, but I don't think that was what was sent.

DR. SCHUSTER: Kathy, if some of your member organizations want to, you know, once you get that information from your group, send it to me.

PARTICIPANT: Absolutely.

DR. SCHUSTER: And we'll make sure that it gets over to the Commissioner and Angie

Parker.

COMMISSIONER LEE: Yes.

PARTICIPANT: I do think, real quick, one more thing that we talked about this morning, and it relates exactly to what Mrs. Pennington said and then Kathy said about the glasses. You know, if you're nearsighted you're always going to need your glasses. It's not something that's going to go away. And are we going to look at targeted case management as being a service like that that if an individual is staying in their community that they can only have it for a set amount of time? And I bring that up because there are individuals that used to get it for years, and it sounds like to me they may need it for a year. So, again, I don't think we can lose sight of that especially when we're seeing limits on the number of hours or the number of units.

COMMISSIONER LEE: I mean, when you look at some of things that are going on, I think, you know, we're going to talk about the waivers here in a little bit, I think that setting a limit is kind of, as Dr. Brenzel said, kind of arbitrary. You always have to look at the

individual needs. It has to be based on those individual needs, and you can't just set an arbitrary limit for everybody across the board, in my opinion.

DR. SCHUSTER: So we have a plan. I love it when we have a plan.

COMMISSIONER LEE: And we have a plan, again, as a group this is not -- you know, if the MCOs are our partners or providers are our partners, and the TACs bring us all together and we will move forward as a team and make decisions as we go forward.

DR. SCHUSTER: I appreciate that, and I think that our TAC has operated as kind of a, you know, a purveyor of information, trying to gather up and gathered up the pipeline and so forth, so we appreciate that.

I had a question asked, Commissioner, about the status of the IMD waivers, both of them mental health and substance use disorder side, so I just wonder if you might be able to tell us where we are with that.

COMMISSIONER LEE: I can speak a little bit to that. So you know that the IMD and SUD, there were components in the 1115 waiver that

Dr. Schuster referenced earlier that we have asked to withdraw. Now, when we submitted our withdrawal letter, we did say that we wanted to keep the SUD piece intact within the waiver. So we have not heard from CMS, yet. They will respond to us with terms and conditions. So what we're doing right now, we're looking at the SUD piece because many of those components were already in our state plan and we're able to do those in the state plan. The IMD, of course, is the biggest piece that we need to kind of figure out going forward and we'll have to do that with CMS's help. In addition, we did ask that the nonemergency medical transportation be allowed to be provided to those individuals who needed substance use disorder treatment particularly the methadone or the medication assisted treatment. So that piece, too, has also -- we have asked to preserve that. So, again, the SUD piece, we're looking to see what's already in the state plan that we are going to continue to provide, but the IMD we are waiting on CMS on for a response to our request to withdraw the waiver.

DR. SCHUSTER: And the IMD part would be your beds?

COMMISSIONER LEE: Yes.

DR. SCHUSTER: Right?

COMMISSIONER LEE: Yes.

DR. BRENZEL: So it's my understanding you're proceeding as if that continues to be authorized and have authorized a waiver for providers under certain conditions, and at that point we're proceeding with that authorization. So we have a number of SUD providers who are now waived above the 16-bed previous based on that, so until we hear otherwise, we're operating --

COMMISSIONER LEE: Yes.

DR. SCHUSTER: Okay. And what about on the mental health side? I was trying to remember that because that was never in the waiver.

DR. BRENZEL: There are other ways where the IMD has been loosened, and if you stay less than 15 days in a facility --

COMMISSIONER LEE: Within a month.

DR. BRENZEL: -- within a calendar month, then those are eligible, and we are working with our MCOs, and some of our MCOs are reimbursing for stays in hospitals that would have

been previously considered IMDs. At this point, that's an MCO network decision about who they would enter into network agreements.

DR. SCHUSTER: That's what I was remembering because Diana from The Ridge is usually here and she always brings up the issue about -- so is it a decision that each MCO can make about whether they're going to reimburse?

DR. BRENZEL: I mean, the way that will -- only states who have managed care are allowed to implement that. It's basically to say that those MCOs can use IMDs as part of their networks, but the only folks who would be eligible to be reimbursed if they stayed less than 15 days. And it's not the first 15 days. It's if the entire stay is less than 15 days. So I can tell you as a provider, myself, from state hospitals, we are getting reimbursed for some of the stays in our state hospitals that are less than 15 days by some of the MCOs.

DR. SCHUSTER: But not by all.

DR. BRENZEL: Right. That's the decision MCOs are --

MR. SHANNON: And is it a rolling 30 days? Is it a calendar 30 days?

DR. BRENZEL: It's a very technically complicated thing logistically to keep track of because my understanding it's 15 days within each month so that if you go in the last two days of the month, those two days count as two, but then, I mean, I think these are some of the logistics issues -- so I think that's made it a very logistically challenging thing to implement and measure and to be sure that we are in compliance with CMS regulation. The last thing we want is a pay back of services, but it has begun to increase some access, I think, although not maybe -- so we are looking at other ways. There are other levers that are in place now to allow states to waive IMD for behavioral health. The best thing we would have to do is if the federal government would see that for what it is, a discrimination against behavioral health and eliminate it at the federal level. We have to operate under the federal rules and CMS rules at this point, but I think that's the long-term answer.

PARTICIPANT: If that reverses back to 16-bed caps, will there be a timeframe that providers will know to shift our model back to how

it was as compared to having larger residential facilities?

DR. BRENZEL: There's also other vehicles within Medicaid to reinitiate that. There could be a new waiver because Kentucky could write a new 1115 waiver if they -- if CMS were to require us, we would have to rewrite, resubmit, public comment period, go through the process. There might be ways to expedite that. There might be ways to do -- there's the Support Act which I think has some possibilities for waiving IMD. I know your staff are very much exploring the best options should there be a decision that that waiver would have sundown and we would have to reapply. Hopefully, no one would do anything precipitously to disrupt. I can't imagine they would require us to suddenly -- that would be very detrimental to the care of many people.

DR. SCHUSTER: Right. But that almost feels like a parity issue as well.

DR. BRENZEL: I mean, I think they're both discrimination issues. I mean, the issue of limitations. The IMD was created in the day where people lived in our psychiatric hospitals and the federal government didn't want

to take responsibility for people who resided for their lives in our state -- that's not what we do. We operate acute care hospitals just like any other specialty hospital service.

DR. SCHUSTER: And I'm sure, Commissioner, that you can't tell us much about the RFP process and so forth because I'm sure you're in the procurement process, but I guess I would ask can you give us any idea about timeframe?

COMMISSIONER LEE: New contracts are supposed to be in place by January 1st of 2021.

DR. SCHUSTER: So all the current MCOs have had their contracts extended to December 31st.

COMMISSIONER LEE: Yes. They'll be in place until December 31st. New contracts will begin January 1st, 2021.

DR. SCHUSTER: So do you have any idea about who we might know who the MCOs are?

COMMISSIONER LEE: (Shakes head)

DR. SCHUSTER: No idea. You can't blame me for trying, just a needling wheedling here. All right. Nothing else you're going to

tell us about that?

COMMISSIONER LEE: Not a thing.

DR. SCHUSTER: Okay. Where are we with the 1915(c) waiver redesign? We've had Pam Smith here at our last two meetings. I think it's been very helpful, and we hear from different people, particularly from the ABI community that are on that.

COMMISSIONER LEE: So, yeah, there has been a lot of hard work and effort put into analysis of the 1915(c) wavers within the Department. There have been several reports. There have been lots of work groups, lots of information. And then when the new administration came in, of course, we have been contacted by several provider groups and organizations that are very concerned about some of the changes that are proposed in recommendations. So what we have done is taken a step back. We've got a little bit of a pause going on. We want to make sure that any changes that we implement going forward have no unintended consequences. The report, as you know, many of you have seen that report. They have some recommendations. Two of the recommendations that we are really looking at are the rate, the rate

survey, and the rate recommendations because there were some winners and losers in those recommendations. I think the ABI waiver providers would have received a decrease in reimbursement rates and some of the SCL providers would receive an increase. So with that pause those rates have not been changed. So as you can imagine, some of the SCL providers are very anxious to know how we are going to move forward as are the ABI providers, and again, we want to make sure there's no unintended consequences. Those rates were developed in a manner to be budget neutral so that there were -- again, budget neutral, there's going to be no additional funds in that program.

Some of the other issues we are concerned about or looking at to make sure there are no unintended consequences are recommendations for assessments. You know that some of our assessments -- or one of our assessments, particularly for the Michelle P. Waiver I think is not based on national standards. The whole goal of this waiver redesign and the analysis and the deep dive into it was to assure that, number one, we are in compliance with federal regulations as it relates to our operation of the waiver. We

want to make sure that our state regulations align with the waiver applications, themselves, and we want to make sure that we are spending our resources wisely to cover as many individuals as possible, because as you know we have a couple of waiting lists. We have a little over 7,000 individuals waiting on the Michelle P. waiting list, and we have, I think, 2,836 on the ACL waiting list.

The governor's budget provided an additional 250 slots for fiscal years '21 and '22 for Michelle P., which would have been 500 additional slots, and then 100 for each year for SCL. And the latest budget, I think the House budget, had cut that down to 100 slots for Michelle P. and 25 for SCL for each year. So again, we have that huge waiting list, particularly for Michelle P., and out of the 7,049 people who are on that waiting list, 70 percent of them are children.

So, again, we are moving forward very thoughtfully and methodically related to the 1915(c) waiver recommendations and got a little bit of a pause on right now until we can kind of figure out what we really need to do going forward

with the programs.

DR. SCHUSTER: So the various workgroups and the structure and so forth is done because there is no activity right now.

COMMISSIONER LEE: No activity, yet. There are some internal communications and we are including our partners to make sure that everyone in there is in alignment with going forward with any recommendation. So right now what we are doing is just reviewing the waiver application itself and the regulation to see if there's any misalignment to make sure that we're not putting ourselves in a position to be out of alignment with any of our requirements and issue or risk an audit finding.

DR. SCHUSTER: Okay. Does anybody else have any questions for the Commissioner? She's a captive audience right this minute. I have her boxed in if anybody has any questions about the 1915(c).

PARTICIPANT: We appreciate you coming.

COMMISSIONER LEE: Glad to be back.

DR. SCHUSTER: And you, as well, Dr. Brenzel.

DR. BRENZEL: Thank you. Glad to be here.

DR. SCHUSTER: Yes, it's really nice, and we were so glad to see Stephanie at the last meeting. Oh, Bart's got a question. Go ahead, Bart.

PARTICIPANT: I have a question and I don't -- I know it's a moving target right now, but I've had a couple of groups contact me today about the Coronavirus type of issues. One is related to providers and Medicaid providers. One is I know that the governor has declared a state of emergency which brings down federal dollars. You may just need to direct me who to ask. Is there any way any of those federal dollars go to providers for additional costs of doing things to prepare for, you know, specifically around providers that have folks living there 24/7, you know, additional recommendations, additional practices beyond what we're currently doing which apparently has a cost associated? Is there any way to tap into some of those federal state of emergency dollars to go to, you know, children's homes, long-term care --

DR. BRENZEL: I don't think either

of us are probably experts in that. I've been asked that question repeatedly. The answer we got is the federal government has allocated resources. It's not particularly clear, yet, in what form and to what amounts those will be allocated to the state and what particular strings will be on that. I think everybody right now is in the primary mitigation and control phase and not even fully able to appreciate what the scope of the economic impact, the provider impact. So I don't think there's any specific answer as to how, who, when, and what, and where those additional dollars -- they're likely to be initially focused on healthcare and mitigation, containment, testing, and treatment. And so beyond that, I think the federal government will help put the strings on where those funds will be allocated. But we'll certainly advocate for the folks that we serve and the providers that serve the folks that we serve, recognizing that this has extra impact on all of you in terms of the things you're having to implement around additional cleaning, additional resources, staff. We are all very concerned, hope all of you are in emergency preparedness mode, preparing contingency plans. This is what's

keeping a lot of us up right now is if we were to lose a significant percentage of our provider network, if our facilities were to close based on not being able to staff them, but I think, unfortunately, that's where our priority is right now rather than on specific economic impacts. We are concerned about individuals who may not be able to work, whether they'll be able to make their payments. I think some of the first priorities I hear are paid leave and sick time and things like that.

PARTICIPANT: Just something to put on your radar because I'm not sure -- I have no idea how that money flows, but just --

COMMISSIONER LEE: We did send out a provider letter today. I'm not sure if you read that, yet, but there were a couple of codes in there, particularly around labs and there were other very brief encounter codes that we are inserting on a temporary basis related to maybe telephonic conversations between providers and members. All the MCOs are also aware of that. We had a conversation with them.

We're staying in contact with the managed care organizations so that we are all on

the same page going forward, and I'm sure that many of you have heard that -- the press conferences that Governor Beshear has been doing about some of the other things that we have done such as lifting prior authorizations for anything related to treatment and diagnosis of the Covid.

Plus, we are allowing early refills on prescriptions up to 90 days. We have relaxed some prior authorizations for drugs that are designed to treat respiratory infections or those with chronic disease, such as COPD, or asthma, or those kinds of things. So we're really focused on how do we continue to provide services to our members without having them to go face to face to a provider. So we're -- as many barriers as we can remove, we are, and we definitely are focused on the health of our member and everyone in the community. I would shake all of your hands, but I cannot.

PARTICIPANT: That was my second question around some of the things face-to-face case management --

COMMISSIONER LEE: Some of those things are outlined in the letter, and it actually goes into specific diagnosis codes, and those

diagnosis codes are covered by Medicare. So we're kind of following their lead right now. This is, of course, we're new so we learn different things every day, and as we learn that information we will post it on our website, and the Department For Public Health is taking the lead on this. They have developed a website COVID19.KY.GOV. Also, if you go there, they have a lot of information on what the state is doing. They have updates on the numbers of individuals and locations of those that are impacted.

Now, the one thing that keeps coming up that would be interested to this group is the opioid treatment individuals who may going -- have -- they have to go have to that face-to-face for methadone. We haven't gotten that figured out, yet, but we're keeping an eye on other states and what they're doing, but that's something of a particular concern for us right now.

DR. SCHUSTER: I was going to say, and I could send out to the group, so if I have your e-mail you've been getting those, the provider letters, but also Charla Hughes sent out some really good information just from the website that I think would be a help to all of you, and I

will send that out when I get back to my computer today because a lot of that was just very helpful.

There also was some stuff, I know the American Psychological Association, I'm guessing some other groups have some advice out there about helping clients deal with anxiety, just generalized anxiety. I'm hearing that from a lot of people. I don't know whether it's from parents who are afraid they're going to get quarantined with their kids for two weeks, trying to figure out -- you all may not remember back in the '70's when we had snow for three weeks and people -- I mean, literally people were -- that was before the days of the internet and so forth, and I got so many calls during that period as a psychologist, you know, will you be on the radio and talk to parents, you know, we could have a help line and so forth.

So we'll send some of that out to you all, but I thought it was very helpful, very helpful stuff.

Anything else for the Commissioner? Anything other questions?

PARTICIPANT: I have one. Commissioner, I just got a, I guess, clarification

on the substituting face-to-face case management contacts 1915(c) waiver participants, and it says if the individual or someone in their home and/or the case manager is symptomatic or diagnosed with Covid 19 or has been exposed, then you can substitute, you know, using technology. So is that true? Do you have to first confirm a diagnosis or be symptomatic in order to substitute a face-to-face or should we do that as a best practice during this interim period?

DR. BRENZEL: What we're hearing is some people are refusing to allow people into their homes now so that it was making it challenging for that compliance. So I think there was some intent to be flexible, but I haven't actually seen the actual language.

COMMISSIONER LEE: I think there is, and to be flexible, and then if that happens, if they have the -- or if they don't have the face-to-face, make sure to keep that documentation in the file for future reference in case of an audit so that we know exactly why there was a telephonic connection rather than face-to-face.

PARTICIPANT: Would this apply to targeted case management, as well?

DR. BRENZEL: The initial was in the 1915 waiver's population. We'll have to look at that, too.

PARTICIPANT: Is there a way to maybe send out a clarification? I just anticipate a lot of questions. They don't want to face recoupment later on a note when they said, well, you should have done face-to-face because no one was symptomatic during this period of time. Are we going to have to prove that or should we err on the side of caution now and just not go to attempt a face-to-face?

COMMISSIONER LEE: Let me go back and regroup with the 1915(c) folks.

MR. SHANNON: You've got to be symptomatic --

COMMISSIONER LEE: Yeah, unless somebody is refusing somebody entering their house.

DR. SCHUSTER: I was going to say because that's that anxiety thing where people are just I'm so afraid, I'm not going to let anybody in.

COMMISSIONER LEE: And we're afraid that there's going to be a huge influx of the

telephonic calls and nobody going in to check on some of those individuals that probably need to be checked on. So we just want to use common sense, you know, just kind of -- kind of use your best judgment about these situations. I mean, if we have an individual in their home and they're there for periods of time with nobody checking on them, I mean, that's not a good thing. You know, you don't know what's going on inside the home if you're just talking to them on the phone, so we want to make sure that all of our members are taken care of, and just use good judgment.

DR. SCHUSTER: If you want to send out anything, Lisa, I'm happy to send that out to the group, and I think both for 1915(c), and it's going to come up around targeted case management as well. All right. Thank you all very, very much.

We usually have -- we have two representatives here from the ABI community and we just give them some time here. You don't have to be an expert in everything. Thank you very much, Commissioner and Dr. Brenzel.

Diane, do you have anything?

MS. SCHIRMER: There are several

things that we're working on. As a group we did oppose the recommended proposed changes to the waivers. Right now, we jointly sent with the Coalition For Brain Injury a letter from the Kentucky chapter of BIAA, and the coalition requesting that no changes be made to the current rates that are in place for brain injury and that actually we get a 10% increase in rate, given that there haven't been rate changes in over a decade, and we provided some other data in that area as well.

Secondly, we are working on some legislation, or before I go into legislation, we also vehemently opposed -- several providers received letters for recoupment of funds seven years ago. And it ranges anywhere from three thousand to 70,000 and this could put some providers out of business, and so we were going to argue that collectively.

DR. SCHUSTER: And is that from CMS?

MS. SCHIRMER: It's from the Department here, but if you look at historically what's happened with CMS at a national level, there was recoupment that put many programs out of

place, but there was a lawsuit that just went against them, and they've had to repay all of those hospitals. So we should possibly take heed. And we have lots of issues looking at the clinical expertise in the departments that we're working on.

Legislatively, we are very hopeful that we will get a brain injury task force passed, and we're working on prevention efforts with TJ's Bill as well for bike helmets.

DR. SCHUSTER: Very good. Are both of those pieces of legislation looking good?

MS. SCHIRMER: They're looking very positive. We're very excited, very excited.

DR. SCHUSTER: I know there's been a lot of rumor in these halls about the length of the legislative session and whether the Covid-19 is going to strike or not, and, you know, the sessions are set in the Constitution to be 60 days and to be finished by April 15th, and to have days to veto and so forth. So they really don't have a whole lot of leeway there, so I'm not quite sure what the solution is going to be in removing every other chair from the meeting room.

MS. SCHIRMER: I forgot one thing.

We would like to get something similar to the SCL rate to take people in the community because that's actually a part of rehabilitation, and we're very much in favor of using data and nationally recognized tests as well as anything else that we can use that's an industry standard. We're trying to say that brain injury is a medical component that is rehabilitative and through this redesign process we've been watered down to look like everybody else and be vanilla, and so the changes that can be -- we have to look at the diagnostic categories. Thank you.

DR. SCHUSTER: Okay. On your plain old boring white paper, going in landscape, I tried to pull some bills that different groups of the mental health coalition and some other groups are following that I thought might be of interest to you, and if I left something out that -- in fact, I don't think I have TJ's law on here, and I had it on before. I don't know what happened to it.

The budget is always the big issue. It is the policy document of the Commonwealth. We were extremely disappointed to see those waiver slots cut by more than half and whether we can get

them back in in the Senate, you know, with those kinds of waiting lists the Commissioner talked about, you know, 7,000 people, 900 people, you know, it's just criminal. No new ABI slots at all.

There is good news we think for the CMHCs and the other quasi-governmental agencies and that is that there is additional money in there for them to meet there.

MR. SHANNON: The governor put in the House maintained -- the House dictated how it was spent, okay, but the governor put the money it.

DR. SCHUSTER: So if the budget -- if that part of the budget stays intact and they don't change the required employer rate --

MR. SHANNON: Contribution, right?

DR. SCHUSTER: Right. Then we're good for another two years, and then we live to fight again in another two years. So there may be some long-term things going on.

House Bill 213, somebody mentioned, oh, over here, the Methodist Home, and that's the unaccompanied minors, but those would actually be kids that are -- help me out, Adrienne, that

actually are deemed homeless. Right?

MS. BUSH: Yes, by Department of Education standards, so it does include house surfing folks and like the economically insecure. So it's broader than the HUD definition, which is good. It's what we want.

DR. SCHUSTER: So it's for the 16 and 17-year-olds, and we assume that it's going to be okay in the Senate? Have you heard?

MS. BUSH: The last that we heard from yesterday, Natalie had -- met with Senator Alvarado but that it's being held up right now waiting for other bills to pass, other Senate bills to pass in the House. It's a charitable --

DR. SCHUSTER: We're at that, you know, standoff here where the House is not going to vote, final passage to the Senate bill, the Senate doesn't give final passage to the House bills that I'm like we can get to April 15th and we'd still be in this because nobody's going to give. So somebody's going to give --

MS. BUSH: Somebody will give. There are no problems with this bill. Everybody likes it, the leadership in both chambers, but it's just a reality.

DR. SCHUSTER: That's an issue, some of you will remember, we have tried to address this issue for a broader group of minors, actually, actually probably age 12, and we've just run into an absolute roadblock with very conservative legislators saying that you're trying to abrogate the rights of parents, and we're saying, you know, there are some kids that really need therapy and they can't get it because of what's going on at home and because of their parents not allowing them and so forth. So I don't know if we'll ever get there, but we're very excited to at least get this little piece in and extend it down to 16.

Creating an Eating Disorders Council, and this is one of those bills that this is the first time it's been here. It looks like it's going to pass. This mom, Melissa Cahill, testified during the interim with her daughter who's been in treatment for ten years, really captured the attention of legislators in both House and Senate. And the truth is that there is almost no eating disorder treatment in all of Kentucky. There's no inpatient. There's very limited IOP, intensive outpatient, or day

treatment programs, so these kids get sent out of state at tremendous costs because the insurance companies don't want to pay anything for it.

So we're excited for this. The council would have both good representation of both physical health and mental health people as well as the Commissioner of the Department of Insurance because we really want to look at the insurance issues; some researchers in eating disorders and so forth.

Mental Health First Aid has kind of become a thing. Actually, a lot of the schools and CMHCs were already doing it for years, so, you know, it's not like this is brand new. But anyway it flew out of the House. It is has an amendment on it to actually kind of begin to look at what could get us into a red flag law or what they call an ERPO, an emergency protective order, which when Paul Hornbeck announced at the beginning of the session that he was going to file that bill, we had three days of protests of gun-toting, rifle-bearing, mask-wearing people in the capitol that was just pretty scary if you all were up here then. So we're not going with the full bill, but what we're doing in the mental health first aid is

saying, you know, one of the outcomes would be to protect individuals from harm. And then we're listing retail establishments as people that could be trained with mental health first aid.

This was prompted somewhat by a personal experience of mine where a friend called me on Christmas day from out of town and finally got through to me and said her stepson was in the middle of an ugly divorce and stormed out of his place of business and went to Walmart and tried to buy a gun and was so upset that the clerk figured out what it was and called the police. And he was then taken to EPS in Louisville and then to Central State and is now in treatment and so forth. And so it kind of, you know, it was that moment of grace where he said the right -- you know, the right thing and somebody actually recognized, did the right thing, so we thought, you know, this mental health training wouldn't be a bad idea for people in retail establishments. Actually, pharmacists have talked about this, you know, because they have to deal with people coming in and being very upset if they don't get their opioids or whatever, and certainly some of our healthcare providers.

But, anyway, we have also a task force on individuals with severe mental illness, and that's one of the House bills that's caught up in the Senate that I think it will pass. We did not put providers and family members and consumers on that because it was real hard. It would have been a task force of about 50 people. So what we're doing is keeping it limited to Medicaid, DBH, the Department of Corrections. We do have a homeless and housing coalition person on this. We have a psychiatrically board certified pharmacist because there's so many issues around medication compliance and medication management and so forth. And then what we're envisioning is that each month that it meets, it will have a different topic, and we'll have all kinds of opportunity for people like we've done today to come and talk and present testimony and so forth. And the hope is to come up with some concrete recommendations about future programs or future funding.

The bills to protect the SMI individuals from the death penalty, actually, Senate Bill 154 came out of the Senate Judiciary Committee. It should be over there for a vote. It's been on the order for the day for several days. We've had

some alerts out on it.

Julie Raque Adams, and I should have had her name in there. So that was Julie Raque Adams has that bill.

We have a Technical Correction to Tim's Law that would extend it to two involuntary commitments in a 24-month period rather than a 12-month period, and Judge Stephanie Burke who is doing mental health court right now in Louisville had testified that she thought it would be -- would widen the funnel and capture more people for Tim's Law. I understand that DBH has applied for a SAMHSA grant, which if they got it would be a million dollars a year for -- I don't remember, Allen, four years of five years?

PARTICIPANT: Four.

DR. SCHUSTER: Four, I think. And they applied for it to be used in Louisville Four Rivers region, which is Paducah, Pennyrile, which is Hopkinsville, and River Valley, which is Owensboro, so kind of Louisville and west. But it would be nice to have somebody to put Tim's Law actually into effect.

Denise Harper Angel's bill may have gotten out actually by the House. It's kind of a

neat idea. It's to put on the back of a student ID a suicide crisis line, sexual assault crisis line, and domestic violence, and actually some good testimony from people, in fact, a school administrator whose daughter committed suicide. I would like to think she would might have seen something and reached out in that moment.

Doing some work, Kentucky Voices For Health, not on House Bill 179, but Senate Bill 150. Surprise billing is that awful thing where you do your homework and you pick a hospital that's in your network and you pick a surgeon that's in your network and then you get home from your surgery and you get a $10,000.00 bill from the radiologist who you had no control over, or the anesthesiologist who you had no control over, and we're trying to put legislation in place that would protect the consumer and let the hospital or the provider and the insurer fight it out in terms of who is going to get paid what. So Senator Alvarado has been very good on that issue. It's probably the third year he's had that legislation and he's really committed to passing it.

Senator Meredith has the prohibiting co-pays, and he's not actually working on it

because we understand that the co-pay regulation will be reformatted and submitted very soon to go back to the way co-pays used to be. Right?

COMMISSIONER LEE: We have an emergency regulation right now just around Covid-19, and when we looked at that definitely, of course, we're waiving all co-pays for those services so we do have the regulation.

DR. SCHUSTER: Yeah. This is going to be a permanent reg going back to -- essentially, undoing what the previous administration in requiring the MCOs to collect a co-pay.

COMMISSIONER LEE: We do have an emergency regulation that's getting ready to drop.

DR. SCHUSTER: We're very excited about that. The pharmacy co-pay accumulator is a hard bill to read because it's really hard to understand. It has to do with really expensive medications that typically are there for multiple sclerosis. (Unintelligible) testified she has rheumatoid arthritis so badly and these drugs are very expensive, and so you get a lot of help from the drug companies with discounts and, you know, this kind of thing, but the insurers are not

crediting people for their deductible and their maximum out-of-pocket, and so when the discount runs out, you're hit with this huge co-pay. So it could whittle away at the deductible and the maximum out-of-pocket, and the discount runs out. You don't have quite as big a lift at that point.

We are fighting hard House Bill 1, and it's a priority or else it wouldn't have House Bill 1 as its number, and it really puts some ugly things into the public assistance world. We got them to take it out, but the original bill had a requirement that if you were -- came out of jail or prison and had a substance use disorder diagnosis, if you did not get into treatment within 90 days that you would lose Medicaid coverage for life. You know, we're like how is this helpful? The response was, well, we tried to be nice to people with substance use disorders, but they just are not getting into treatment, and so we're going to make them do it. And it's working.

PARTICIPANT: I believe I heard somebody say in front of the committee of one of the bills say forced treatment works. And I just wanted to say in what universe?

DR. SCHUSTER: Right. So there was such an uproar about that that they did take that one out, but there are still some things in there around the EBT card, which is what you use for SNAP and other things, that if you are almost accused of fraud because it's a hearing officer kind of thing three times then you would lose all of your public assistance benefits. So you would lose SNAP, you would lose Medicaid. I'm not even sure legally that they can take away Medicaid in that kind of situation. But there are some really still extremely punitive things in there, so we have continued to fight it. We've been working with senators. We did get some changes in it on the House floor.

Senate Bill 29 is not going anyplace.

Senate Bill 30 is interesting, and I suspect that the administration has had some response to it. Senator Meredith has had this bill for several years, and that's the putting a limit of three MCOs. And, of course, you all are in the midst of your RFP, and I think that the RFP says three to five. Do I remember that? Possible MCOs or at least the last one did.

COMMISSIONER LEE: I haven't even

reviewed this.

DR. SCHUSTER: Okay. So it would be interesting to see if this bill becomes law and then there's some conflict with what the administration does.

Senate Bill 50, I'm really, really excited about. How many years for those of you who have been coming to the BH TAC all these years, how many times have we made the recommendation -- in fact, it's in the minutes of our last meeting -- that we have a single formulary, that we go back to knowing what the formulary is so that we all know what the preferred drug list is, so that we all know what the rules are, so that our poor, overworked prescribers are not every time trying to having to submit all the paperwork to get a prior authorization and so forth. And Senate Bill 50 was not developed for that reason. It was really developed to kind of go after what to call the PBM, the pharmacy benefit managers, but one of the outputs from it is to have a single formulary. And it looks like that bill is going to pass, so we are really excited about it because we have made that recommendation forever.

I put sports betting on here, not because we have a dog in that fight, but we worked for so long with the Kentucky Council on Problem Gambling, and this bill has the language and the funding to support education and treatment for problem gaming, and that group -- some of those folks have worked for years to get into that.

This bill is interesting because it passed the House on January 16th, and it has never been voted on by the full House. So the backstory, in case you're interested in politics, is it's a republican bill, it's a republican sponsor. He has the votes to pass it, but it would require democrats who are willing to vote on it because they want to -- they like gambling, I guess, for one thing, but they also want the revenue to come in to the state. So they're more than ready to vote on it. He wants it to be predominantly republican that are voting to pass it, and he can't get most of his caucus to go for it because so many of the republican legislators are very religious, very moralistic, very conservative, and they're just simply opposed to expanded gaming.

So I don't know whether he's going to

finally bite the bullet or not. I mean, he's going to run out of time, and I'm not sure the Senate is going to act on it anyway. But he has literally been sitting on it for almost two months, and what he has done in the meantime and one of my -- two of my bills have been caught up in this, if he has bills in his committee -- this is Chairman Koenig, this is the L & O Committee, and the sponsors of those bills are not supporting the sports betting bill, he's not calling those bills. So you have a bill that we have left for psychology, reciprocity, it's called a compact, but nobody's opposed to it. I can't get a vote on it. I have all the votes passing all the way through, because the sponsor is unwilling to support. That's where you just kind of walk away. I just can't think about the process, you know. Those who love sausage and the law, and that's one of those where -- I could go crazy thinking about this. So I'm just not going to do it.

Representative Moser has filed a mental health parity bill, and it's interesting that Dr. Brenzel has talked a bunch about how many of our instances are not covered by parity and they

really should be. So these are on what they call the hard limits just to at least start with day restrictions on therapy or days in the hospital and those kinds of things. It's late in the session so I don't know whether it'll get any traction or not.

A bill to add -- to create a new TAC, so create a new technical advisory counsel, and also add a seat to the MAC. So we have a talked in here, and a lot of groups are very concerned about what they call the justice-involved people, so people that are coming out of the -- usually the prison system, but also the jail system, many of whom, as you know, have substance use disorders. And so they have all kinds of strikes against them. They can't get housing. They can't vote. You know, they can't get jobs. You know, there's all kinds of things. We know that people come out of those situations and don't get their Medicare restored right away. So they fall through the cracks, they don't get into treatment, and so forth. So a group of folks that have been working in the recovery community for a long time, so there would be a representative of the MAC, Medicaid Advisory Council, that would represent

that population of people. So a Medicaid recipient who represents a population of a justice-involved person. And then they created a TAC, and it has substance use providers, CMHC, housing. You're on it, I think, Adrienne. So they tried to -- they have the criminal justice people, the court system, trying again to kind of build a network around that group.

So we took advantage of it. The Brain Injury Association of Kentucky has wanted to have a seat on our TAC, so we put them in. And then the consumer TAC is four people. One of the groups that is -- that had a domination spot doesn't exist anymore, was the Council on Aging or something, so they've added AARP Kentucky, and they've added a group that's on the community health workers. So I don't know how familiar you all are, but that's a really interesting group in terms of people that work out in the communities and help people get services. So it really fits with the Medicaid thing. So that's moving along.

Susan Westrom had a bill on sober living homes because they were not certified, and I understand that that terminology is problematic. So it's being renamed as the recovery residence

task force. And they're looking at certification, but also issues out in the community and, again, housing, obviously, is all through -- up and down.

Diane, this is your task force on services for persons with brain injury, right? So you're over in the House.

MS. SCHIRMER: We got through --

DR. SCHUSTER: The House committee?

MS. SCHIRMER: The House committee.

DR. SCHUSTER: There's a bill, and I don't know why it's not moved, the Representative Hart and nine co-sponsors, and it's rights of persons with intellectual disabilities, and it's really just kind of one of these, you know, apple pie and motherhood. I'm not sure why it's not moved.

MR. SHANNON: It's the opposition of rights, really.

DR. SCHUSTER: Right. And then the other bill, Steve, you want to speak to the carveout for mental health for the MCOs?

MR. SHANNON: I had a conversation with the sponsor back in the fall and thought we agreed not to file, and last day he filed. So the carveout and the rationale is it's really pension

based. I don't anticipate Representative Graviss will pass that bill.

DR. SCHUSTER: Yeah, being the democrat in the House --

MR. SHANNON: And running for the Senate.

DR. SCHUSTER: And being House No. 590, which means it was filed the last day --

MR. SHANNON: Did not expect it to be filed.

DR. SCHUSTER: The other one that I forgot to put on here that's really interesting, and I don't know remember the bill number off the -- is Morgan McGarvey's bill. I call it the WDRV bill. So this is the awful case that WDRV TV has highlighted for the last year of a gentleman who was found incompetent to stand trial. He had allegedly raped somebody, was found incompetent to stand trial. Central State Hospital would not keep him because he didn't meet the criteria for benefitting from hospitalization.

MR. SHANNON: Senate Bill 188.

DR. SCHUSTER: Senate Bill 188. Told the judge that he was going to go out and hurt somebody. Went out and raped an 8-year-old

girl and gave her a traumatic brain injury during the course of that attack. So you can image the uproar in the Louisville community with this. Senator McGarvey that day said, I'm going to file a bill to solve this problem.

I thought, oh, Morgan, you don't understand how complicated this is.

So we have been meeting and working on this. The Department of Behavioral Health has been very involved in this. Every kind of judicial person in the world has been involved in this. These discussions have gone on and on. I don't think that bill is going to go anyplace, but if you want to take a look at it. It creates a new section of 202, which would be 202-C, and it would literally be for these people and we're hoping there are not a lot of them. The Department of Public Advocacy thinks that there are maybe 20 kinds of cases like this out there. I don't know, but there might be more, but if you create a category and someplace to send them, there's going to be lots. But it's for people that, like this gentleman, have been incompetent to stand trial, don't meet the criteria, as we think of it under 202-A, and then would probably

create a unit out at KCPC, which is the Kentucky Correctional Psychiatric Center, try to restore competency. Apparently, there are some programs to do that. That's not my expertise at all.

PARTICIPANT: And you don't have to have to have a mental illness and you don't have to benefit for treatment.

DR. SCHUSTER: Yes. You don't have to have a mental illness and you don't have to benefit from treatment, so they would essentially hold folks for a year at a time and then review so that would keep people safe. My guess is if it passed, the ACLU and DPA and a bunch of other people, probably PNA would go after it big time. I mean, there really is no solution.

MR. SHANNON: There's a physical matter.

DR. SCHUSTER: Yeah, there's a huge physical amount, even to just use an already existing facility out there and so forth.

And what's TJ's Law?

MS. SCHIRMER: I can send it to you. I'm a little fried right now.

DR. SCHUSTER: Any other bills that anybody is working on that we didn't put in here?

I thought it might be helpful for you, and I'll send this out electronically to keep an eye on things. You know, we are down to day 45. So three-fourths of the way through, not that I'm excited about it, but, yes.

Do we have any new recommendations to the MAC?

MR. SHANNON: I think we're waiting on data.

DR. SCHUSTER: Yeah, I think we'll wait maybe after the next meeting when we get our data and know where we're going.

Anybody have any other issues or updates that they would like to bring up?

The MAC is meeting on March 26th over at the CHR building in the public health conference room.

COMMISSIONER LEE: Dr. Schuster, I think we may have to change that because -- and we'll let you know. Public Health contacted us and said they are going to reserve that space for, I guess, emergency management meetings and things like that associated with the Covid-19 issues. So we'll make sure that we give you -- looking for another place. I'll make sure that she gets the

information to you about that.

DR. SCHUSTER: You know, that makes sense because I was with Beth Barton, who is the chair of the MAC, earlier, and she said, we can't find a place to meet. I suggested to her that, you know, she could meet in here if you do it at 2 o'clock or you do it at 1 o'clock. You can't do it at 10 during the session is the problem because they've got all the committee meetings and so forth. But thank you about that.

Our next BH TAC meeting would be on May 13. Of course, all of this is subject to Covid-19 and other things. And I meant to find out the consumer TAC meeting dates, and I will send those to you because that's an interesting TAC to go to, actually. Emily Beauregard from ABH chairs that, and they've raised some really good issues, I think, particularly in terms of helping more consumers with disabilities to fully participate on the TACs, on the MAC, at the meetings, and so forth, and really giving them some assistance in doing that. So we will do that.

I guess that's all that I have. I will send out to you the Covid-19 stuff. Is there

anything else?

Thank you all. I'm delighted to have new people here, so I hope you'll come back again.

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(Proceedings Concluded at 3:55 p.m.)

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REPORTER'S CERTIFICATE

STATE OF KENTUCKY)

COUNTY OF FRANKLIN)

I, Kathryn Marshall, Court Reporter, and Notary Public in and for the Commonwealth of Kentucky at Large, do hereby certify that the facts as stated by me in the caption hereto are true; that the foregoing answers in response to the questions as indicated were made before me by the witness hereinbefore named, after said witness had first been duly placed under oath, and were thereafter reduced to computer-aided transcription by me and under my supervision; and that the same is a true and accurate transcript of the proceedings to the best of my ability.

IN WITNESS WHEREOF, I have affixed my signature and seal this 27th day of March, 2020.

_____

Kathryn Marshall, Court Reporter
Notary Public, State-at-Large
Notary ID 608218

My Commission Expires: August 4, 2023